**Commonwealth of Massachusetts**
**Group Insurance Commission**
**P.O. Box 8747 • BOSTON, MA 02114-8747**
**(617) 727-2310 www.mass.gov/gic**

# INSURANCE DATA FORM (IDF)

*PLEASE PRINT CLEARLY*

This form is required for new enrollments in any Group Insurance Commission family health plan and for any changes in spouse or dependents. Complete it and any other health plan forms provided by your Group Insurance Coordinator and return them to the Coordinator. If you are a retiree, please return the form to the GIC. Please PRINT clearly. Incomplete forms will be returned.

**CHECK ONE:** ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

**Important:** You are required to provide a copy of a marriage certificate, birth certificate, separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. Failure to provide this documentation will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must provide proof of other coverage.

## INSURED INFORMATION

1) Social Security Number _____–_____–_____ 2) Date of Birth ____/____/____ (Month / Day / Year) 3) Sex ☐ M ☐ F

4) Name _____
Last First Middle

5) Address _____
Street

_____
City State Zip Code

6) Are you enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim # _____

7) Health Plan (Check one)

| | | | |
|---|---|---|---|
| ☐ Fallon Direct | ☐ Health New England | ☐ UniCare State Indemnity/Basic | ☐ Medicare Plan |
| ☐ Fallon Select | ☐ Navigator by Tufts Health Plan | ☐ UniCare/Community Choice | Fill in name of Medicare |
| ☐ Harvard Pilgrim Independence | ☐ NHP Care – Neighborhood Health Plan | ☐ UniCare/PLUS | Plan: _____ |

## SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse, who will be covered under your family plan. Married children are not eligible. Please provide all Social Security Numbers and **exact** dates of birth for each dependent. Attach separate sheet if additional space is required. Coverage for children ends at age 19; to continue their coverage you must complete and return to the GIC a Dependent Age 19 and Over Application for Coverage.

| Last Name | First | Middle | Relationship | Date of Birth | Sex | Social Security Number |
|---|---|---|---|---|---|---|
| | | | | | | –––– |
| | | | | | | –––– |
| | | | | | | –––– |
| | | | | | | –––– |
| | | | | | | –––– |

Reason for addition or deletion: _____ Effective date: _____

## SPOUSE INFORMATION

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number _____ Address of insurance company _____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number _____

## FORMER SPOUSE

Name _____ Social Security Number _____–_____–_____ Date of Birth _____ Date of Divorce _____
Last First Middle

Address _____
Street City State Zip Code

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

## IMPORTANT: YOU MUST SIGN BELOW

Signed under the pains and penalties of perjury, I certify that the information I have provided is, to the best of my knowledge, complete and accurate.

Signature _____ Date _____

**ACTIVE EMPLOYEES:** RETURN COMPLETED FORM TO YOUR GIC COORDINATOR. **RETIREES:** RETURN COMPLETED FORM TO THE GIC

Form IDF 3/08 10,000

**FOR GIC COORDINATOR USE ONLY** **Dept. ID # or Agency/Division #** _____

Name of GIC Coordinator _____ Agency Telephone Number _____

Agency Name _____

Agency Address _____

**FOR GIC USE ONLY**

Entered _____

Verified _____

Date _____